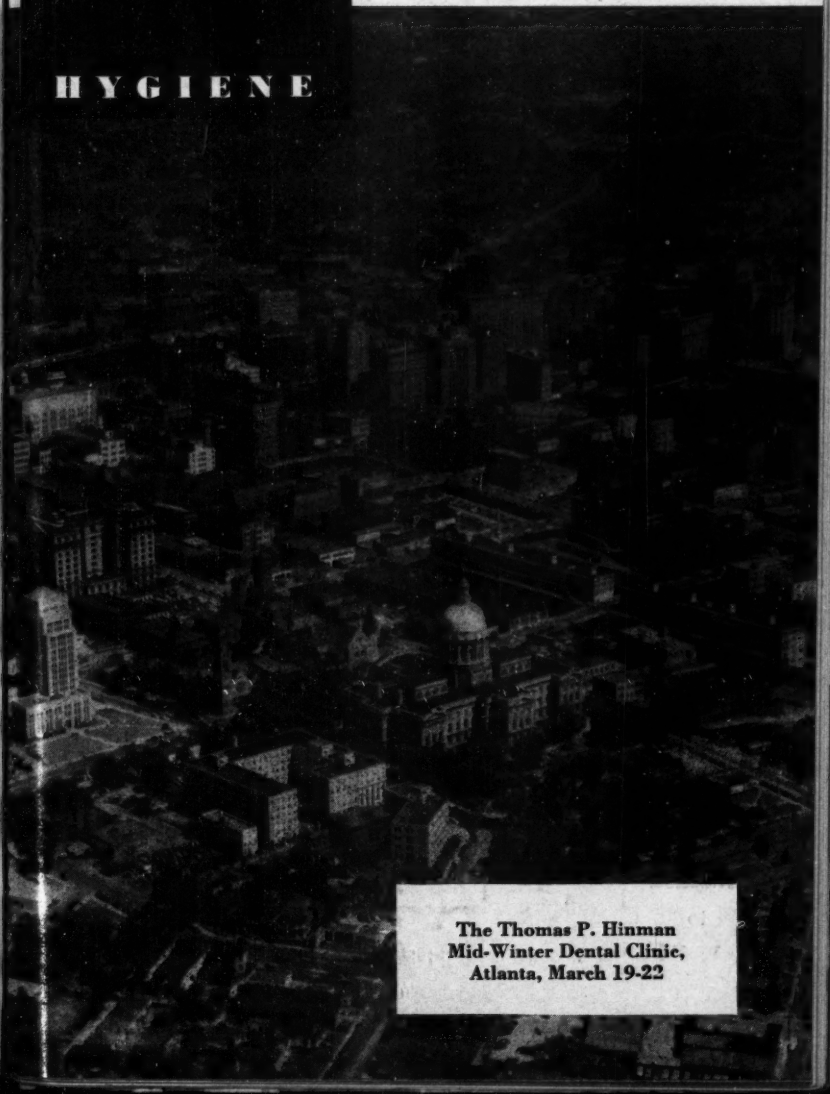
MARCH 1950

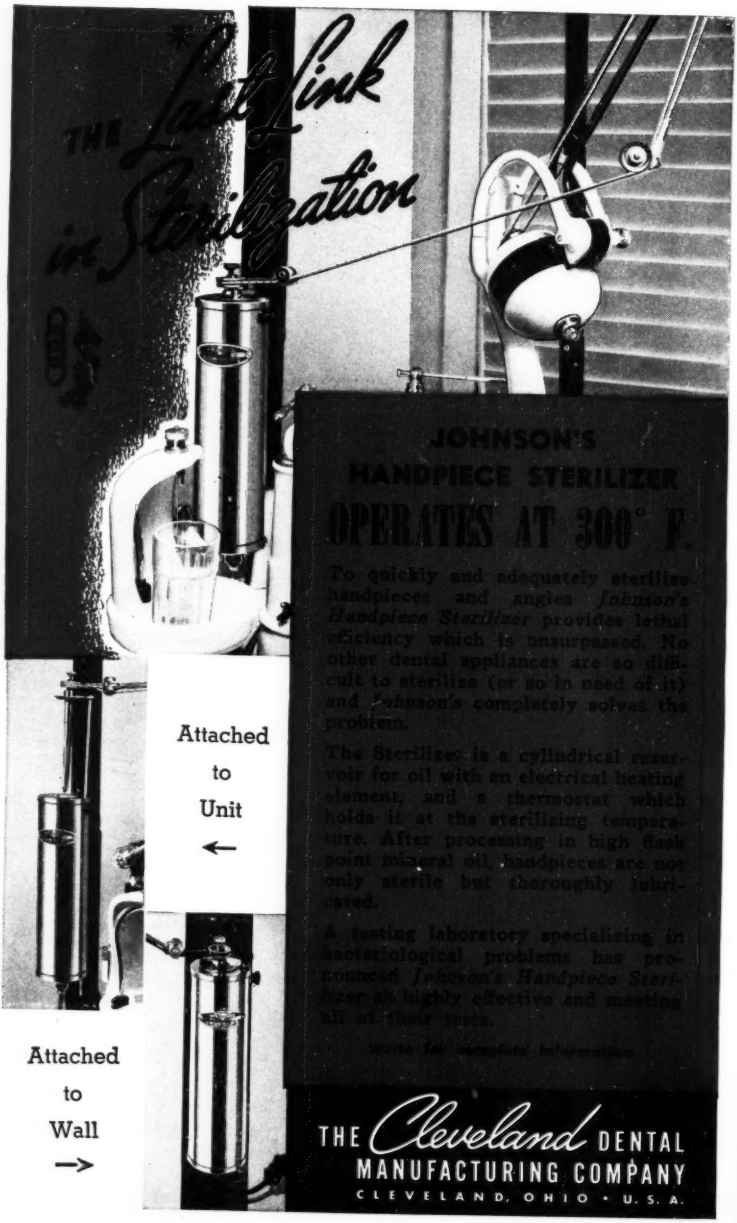
HYGIENE

In This Issue:

DENTISTRY'S GROWING PAINS



The Thomas P. Hinman Mid-Winter Dental Clinic, Atlanta, March 19-22



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CLEVELAND, OHIO • U. S. A.

By Mass

The Publisher's CORNER

No. 344

Poets' Corner

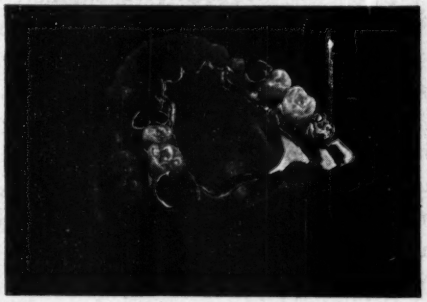
IN JANUARY, this department published a poem of unknown authorship, a copy of which had been given to me by Doctor Don Bartlett. It was suggested that "maybe some CORNER customer knows the author's name and will write in about it." Well, the ink was scarcely dry on January ORAL HYGIENE when in romps one of the lads with a letter about it. Doctor John O'Neil Egan of Dorchester, Massachusetts, wrote: "One of Don Bartlett's chums of that justly famous 1918 class at Tufts dug that poem from under his desk blotter. It had as a companion in hiding one by Dayton Dunbar Campbell entitled 'Doubt and Fear.' "

That same day a letter came from Dayton himself giving the same information and enclosing, not "Doubt and Fear," but a poem he wrote six or seven years ago for his college paper *The Bushwhacker*.

A letter to Doctor Earl Ammons (who conducts his own

craftsmanship–

NOT
conveyor-
belt
methods



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column in *Dental Survey*) brought a letter confirming his authorship. Earl wrote: "It seems that you have enough evidence to convict me of writing the 'If' parody which recently appeared in your CORNER. I might as well plead guilty. For this to come to life, after being interred for so many years, convinces me more than ever that there can be no perfect crime committed. I am enclosing a copy of the short-lived *Mushbite*, which originally contained the parody, and will explain the occasion for its birth."

The Mushbite which Earl sent me is the second issue of the little magazine; it was subtitled "An Impractical Periodical for Practical Dentists." *The Mushbite's* format was patterned on that of the late great Elbert Hubbard's little *Philistine*—butcher-paper cover and all. Earl was editor and publisher; his magazine was a quarterly. The October 1936 issue he sent me carries the "If" parody in the center spread. A note explains: "The following recipe for a successful dentist, reminiscent of Kipling's 'If,' was written by the editor in 1928 after attending a dental meeting at which Doctors Dayton Campbell, A. L. Walters, C. R. Lawrence, and the late Philip R. Thomas were the lecturers. It is given here by request."

The rest of this old issue of *The Mushbite* is mighty interesting, too. But I better not pinch any of it: Earl may want to use some quotes in his own column.

Now let's sit back and listen to Dayton Dunbar Campbell sing his "Song of the Commonplace":

I'll sing you a song of the real commonplace,
Of the many small things that our dentistry grace;
Of burs, and of knives and of chisels all sharp,
That hymn a sweet tune like Terpsichore's harp.

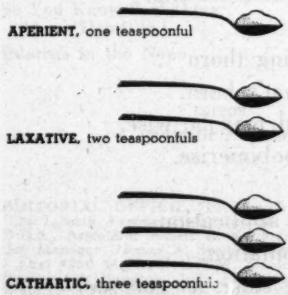
Of getting things ready to start to begin,

Convenient

for you.

for your patient

the saline laxative–



APERIENT, one teaspoonful

LAXATIVE, two teaspoonfuls

CATHARTIC, three teaspoonfuls

Whether your patient needs a laxative, or an aperient, or a cathartic you'll find it more convenient to write Sal Hepatica on your prescription pad. No need to specify all the ingredients of three separate formulas, just prescribe Sal Hepatica and indicate the dosage.

Your patients will find Sal Hepatica convenient, too. No cluttering of shelves with bottles of different laxatives when one will serve. They'll like its pleasant taste, its effervescence—and, of course, its prompt, gentle action.

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Of stirring your mixtures while still they are thin,
Of oiling tight joints and absorbing lost motion,
Of using sharp pumice in sloppy solution.

Of spatulas hot that will hit the right spot
And do a job lacking no tittle or jot.
Of waxes so strong and so hard and so tough
That they rate with the honey bee's exudate stuff.

Of porcelain teeth looking somewhat abused,
But artful appearing, as if they'd been used,
Of clear lined striations, fluorescent and true,
To freshen appearance and start life anew.

Of flasks that are clean and precision that's right,
And free from greases, and hammering blight,
Of index-ed casts poured out neatly and dense
To resist a pressure that should be intense.

Of a well-tinned bright matrix, for "dope" means confusion,
Of a hydrocal cap that preserves the occclusion,
Of facial dimension, bad chin chops effacing,
Of centric relation, with the gothic arch tracing.

Of using experience, a sharp piercing thorn
To puncture each veil of illusion that's born,
Of consulting with others, whose aid may be wise,
And keeping quite active lest you polymerise.

Add now the great genius, of close application
Inextricably linked with a good reputation.
Then of things commonplace I have sung, as you see,
That makes for success in all good dentistry.

VOL. 40, NO. 3

Oral HYGIENE

MARCH 1950

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AS MORE TEETH ARE LOST FROM NEGLECTED GUMS *THAN TOOTH DECAY—*

why not indicate Forhan's with massage as a beneficial home adjunct to promote firmer, healthier gums!

Some of your patients may be confused by the avalanche of claims and counter-claims of new dentifrices and may forget, as you know, that more teeth are lost from neglected gums than tooth decay.

According to the documented results of a clinical investigation, when individual examinations were given to 1048 patients by impartial practicing dentists, 795 were found to be Gingivitis cases. 564 were first given prophylaxis, and all patients were instructed to brush their teeth and massage their gums twice daily with Forhan's toothpaste.

95% of Gingivitis Cases Showed Improvement in 30 Days

After 30 days, 95% of the Gingivitis cases showed definite improvement, and 100% of those with normal gums had maintained them so. Because of these findings, may we count on your continued acceptance and recommendation of Forhan's with massage as a precaution to help prevent gum infection, and as a valuable adjunct to your professional treatment in Gingivitis?

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FOR CLEANER TEETH AND GUM MASSAGE

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Picture of the Month

DELICACY OF control is demonstrated by Doctor Howard E. Kessler, Cleveland dentist, as he substitutes dental floss for leather reins in riding his Toby O'Toole, a former Cleveland police horse. Thanks to the excellent training given by the Cleveland Police Department, Doctor Kessler's horse is so sensitive to touch that he can perform all the riding maneuvers without breaking his dental floss reins.—*Henry Berlon photograph, Cleveland, Ohio.*

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

Straight Teeth *May Mean* *Crippled Faces*

BY H. C. POLLOCK, D.D.S.

WITHIN THE last few years, articles that advocate orthodontic extraction, aided by subsequent natural migration of children's teeth, have appeared in dental journals. It is presumed by the authors that this method will expedite and even offset much orthodontic treatment.

Without doubt, orthodontics is the most growth-minded department of dentistry. Of all the various departments of scientific medicine, the pediatricians are growth-minded far beyond any other group. The explanation seems to be that pediatricians treat diseases of children and since growth is a sharp manifestation in the young, they know that its velocity, vigor, and urge are definitely linked with the general health of each patient.

According to their view, in times of rapid growth acceleration the body is under metabolic stress, and the probability of nutritional imbalance is great. They contend that with virtually every disease process there is impairment of growth, a slowing up of metabolism, affecting the teeth, jaws, maxillary and facial bones, as well as all other parts of the body.

Review the orthodontic literature of the last ten years, and you will find that a commendable amount of research has been done on the growth problem in connection with the development of the teeth, jaws, and cranium; and much has been learned about

Editor of American Journal of Orthodontics points out the speculative angle of early extraction of permanent teeth as a means of anticipating migration.

growth patterns of the maxillary area.

The articles written on this subject alone would make a tremendous volume if published in book form, and they should be read by all who intend to correct malocclusion.

Orthodontics, the first specialty of dentistry, expanded largely because its workers cast about freely in other fields of science to learn more about their problem. Workers in this field are hungry for knowledge at an advanced level in the growth field, and strong evidence of this fact is shown in orthodontic programs and literature of the last twenty years.

Migration

Read some of the articles now being published; listen to the informal comments of dental and medical colleagues; read recent articles published in current issues of dental journals about extracting children's teeth and allowing them to migrate; read about compromise treatment—the same kind that was practiced about the time Sherman marched to the sea, and before modern orthodontics came into being. Even though difference of opinion is regarded as a healthy condition in a democracy, you will see unorthodox and unaccepted methods advocated that are neither practiced, taught, nor approved by orthodontic teachers and researchers.

The migration of children's teeth subsequent to extraction is not new. As the well-known author and orthodontist, James D. McCoy, puts it: "If you go back through the history of orthodontics you will find that others have advocated and practiced the same thing. They have tried to establish a formula to solve the orthodontic problem instead of just advocating the removal of teeth, if and when such a procedure would be practicable and helpful. In 1927 Doctor Henry F. Libby and his son, Arthur A. Libby of Boston, published a book entitled TREATISE ON A NEGLECTED PHASE OF DENTISTRY. In it they advocated the removal of all four first permanent molars."

The Libby ideas were never accepted by orthodontists because men of wide clinical experience knew that when a growing child's four first molars are extracted the bulk of the growth of the maxillary area is reduced exactly "four first molars' worth."

Every orthodontist knows by experience that the extraction of permanent teeth for children is a speculative procedure insofar as the ultimate effect upon contour of facial bones is concerned. They know that if extraction is done at all it should be followed by painstaking orthodontic treatment, and

then only after they have made careful diagnosis and plans to offset retarded growth.

In a word, the end result, straight teeth, means nothing if facial development and expression are arrested or distorted in the process. Such treatment is a speculative procedure at best.

Orthodontics is about fifty years old. Its record is good. It is hardly reasonable to suppose, therefore, that its workers do not know a great deal about the results of extracting children's teeth while they are in active growth stages.

This much is certain: The end result manifest in facial expression, incident to the early extraction of several permanent teeth, cannot fully be revealed until maturity.

Whatever is good and wise treatment is approved by use, adopted by conservative practitioners, and made permanent. The part that is lost is the part not worth keeping.

Few have the courage to practice the extraction and "see what happens" treatment. To impress orthodontists with the merits of any such procedure, authors should record sharp photographs of the child's face before and after treatment and at maturity. If the photograph at maturity does not reveal what some have termed "the edentulous look," then treatment may not be regarded as a hopeful experiment.

Orthodontists would like to see the treatment simplified, but the answer is not in the extraction of children's teeth with the hope of subsequent migration. This is hazardous and may partly correct one deformity and create a more serious one in the contour of the face in the region of the lips and nasal area.

8015 *Maryland Avenue*
St. Louis 5, *Missouri*

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ORAL HYGIENE AWARD

This article by H. C. Pollock, D.D.S., has won the $100 ORAL HYGIENE award for the best feature published this month.

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TELEPHONE EXTENSION PROGRAM—SERIES II

ON NOVEMBER 13, 1950, the University of Illinois College of Dentistry will begin transmitting the second series of its Telephone Extension Program. The first series is now being sent simultaneously to 163 dental groups from cities over the United States and Canada.

The new series is made up of five two-hour round-table discussions and symposia on Current Advances in Dentistry. It originates in Chicago and is assured by the American Telephone and Telegraph Company of clear, unbroken transmission. The faculty represents eleven different universites and comes from eleven states and the District of Columbia.

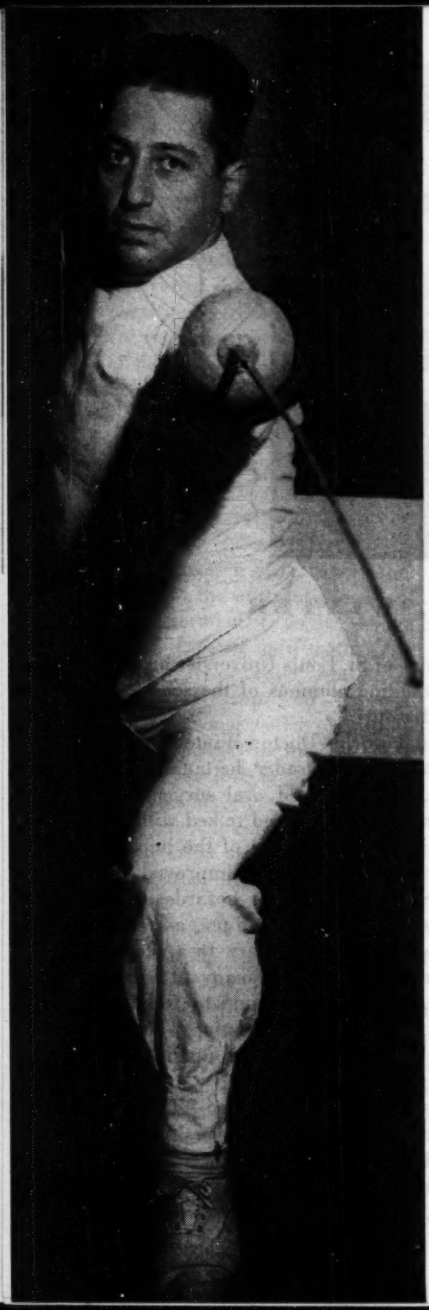
Further information may be secured by writing to Doctor Saul Levy, Telephone Extension Program, University of Illinois College of Dentistry, 808 South Wood Street, Chicago 12, Illinois.

GEORGE B. WINTER

THE NEW DEPARTMENT of Oral Surgery of St. Louis University has been dedicated to the memory of an outstanding alumnus of the school, the late George B. Winter of St. Louis, Missouri.

Widely known throughout the dental world, Doctor Winter won the warm personal regard of many dentists. As a crusader, he taught better methods for the extraction of teeth. He sponsored oral surgery as a specialty; he coined the word *exodontia*: he wrote and talked with tireless energy, describing better methods for the removal of the impacted mandibular third molar—an operation he greatly improved and simplified. He perfected a technique that reduced the hazards of this operation to a minimum. His enthusiasm for his technique, as well as his profession, was boundless. He was never too weary to write and talk about it, and he charted a scientific course that many of his colleagues are now following and will, no doubt, continue to follow so long as dental practice continues. For these contributions and his numerous professional activities, his profession conferred upon him all of its most important honors.

The world has advanced much in dentistry because of Doctor Winter's contribution. It is appropriate that St. Louis University should dedicate its new Department of Oral Surgery to one of its best-known and outstanding graduates, a pioneer in the specialty of oral surgery.



FENCING DENTIST

BY MYRON WEISS

NEXT TO THE mouth, the hand is the most versatile servant of the mind. Each is a wonderful basketry of muscles obedient instantly and precisely to the will and whim of thought. The wave of hand and flip of tongue are related gestures.

In most of us the mind selects one or the other for its preferred tool. We are either talkers or doers, prattlers or battlers, speakers or handlers. That is the biologic basis for the fact that few dentists can make an effective speech, or produce an effective essay; writing being but second-hand to talk.

On the other side, dentists can usually turn their hands to almost anything. A dentist is the world's all-round marksman—Doctor Emmet O. Swanson, of Minneapolis.[1]

[1]Bryan, W. T., "The World's Greatest All-Round Marksman". ORAL HYGIENE 39:1696 (November) 1949.

Daniel Bukantz, United States Champion Foilman at thrust.

New York exodontist keeps fit wielding foils.

Another dentist is the National Open golf champion—Doctor Cary Middlecoff, of Memphis.[2] And a third dentist is one of the top fencers in the world—Doctor Daniel Bukantz, of New York City.

Doctor Bukantz, who stands 6 feet 2 inches, spans 6 feet, and weighs 195 pounds, is the National Foils Champion and the New York Metropolitan Epée Champion. Rarely in fencing history has a swordsman held championships with more than one weapon. At the 1948 Olympic Games in England, he was a member of the United States fencing team, and won the best record of the whole group. The Americans as a team won only fourth place, after the French, Italians, and Belgians; fundamentally because among European contestants fencing is virtually a profession, whereas for the Americans it is, for the most part, a hobby.

It has been Doctor Bukantz' hobby since he attended the College of the City of New York, where he was Intercollegiate Champion with the foils, and through his studies at New York Dental College, class of 1945. During the last war he had no time to play at swordsmanship of any sort. He was dental officer with the 16th Armored Division in Arkansas and with the 87th Infantry in the European theater. At the end of active service he held four battle stars, the combat medical badge, and the rank of captain.

Refined Sport

Fencing is a refined and stylized form of mock fighting. It developed, however, from the tough necessities of hand-to-hand battling with swords and knives. When gunfire made manual weapons obsolete, sword-play became a public amusement performed by rugged bruisers on raised platforms which had rope guards to keep performers from backing off onto the spectators. This was the origin of our present boxing rings. For when "gentlemen" took up fencing, the gladiators took up prizefighting. Boxing is not yet a "gentlemen's" sport, although the Marquess of Queensbury promulgated the current rules for contest boxing, and one World's Champion was "Gentleman Jim" Corbett and another was James Joseph ("Gene") Tunney.

The contest fencer pretends he is dueling to the death. But he must never mar his opponent—only touch him with the tip of his weapon. To prevent any injury, fencers wear masks of strong wire mesh and close-fitting costumes of tough cloth.

For these competitions there are three standard weapons to be

[2]Unger, H. F., He Fills Cavities With An Iron, ORAL HYGIENE 39:1512 (October) 1949.

Doctor Bukantz illustrates exodontist's grip on the fencing foil.

used: foil, epée, and saber.

The foil is a slender, pointed sword with no cutting edge. It is a fast weapon. The target is the opponent's torso. Touches to mask, arms or legs do not count in scoring.

The epée is heavier and longer than the foil. Its play resembles the etiquette of the duel. So the opponents may lunge at each other from toes to scalp.

The saber, which cavalrymen used to wield, has both a point and a cutting edge. With thrust and cut the fencer may strike at any part of the body above the legs—at hips, torso, mask and arms. The saber is more a weapon of force than the foil and the epée. These latter require much more delicacy and precision of handling. Doctor Bukantz became champion with foil and epée, of course, because he uses his weapons with skill and quality. For the same reasons he is an able and successful exodontist.

Fencing, he insists, is a sport in which the spectator can take virtually no vicarious part. Even with fishing you have to have an audience who can see, appreciate, and report your skill in working in your catch. In tennis and golf you can see each swing and stroke. In boxing you can see the blow moving and hear the punch. And in chess and checkers you can, of course, play the game better than the matchmen.

But with fencing there is just no use watching. Two men are there on a narrow strip of canvas, each matching all his body, all his wits, and all his perceptions against the other. The flick of a steel point is all that is needed for score. The tip may move so swiftly, so slightly that the human eye is incapable of noting.

Therefore, fencing competitions

require two to four judges and a director. The judges intently watch for touches and the ritual with which they may be made. At touch or foul they call sharply to the director, who immediately stops the bout. The two again take their stance, touch weapons, strain shrewdly. A tense muscle fibrillates; a wrist yields. Thrust—parry—lunge—thrust—score.

Despite all the watchfulness on the part of the judges, they may miss seeing a touch, or they may think they saw one. The fury of the fencer who thinks himself so wronged is the most explosive in all amateur playings. Therefore, to reduce chances for such error, the epée—the weapon whose play most mimics thrust-to-kill dueling—is specially constructed with sharp points which tear threads in the jacket or otherwise leave definite evidence of a touch. Then, to make doubly sure, the points are often inked with red.

A bout reduces the fencer to sweat and weariness. Doctor Bukantz loses up to five pounds in each competition due to the heavy protective uniform and to the physical, mental, and emotional tenseness. Saber and foil bouts last ten minutes; epée bouts seven.

As a recreation for dentists Doctor Bukantz recommends fencing. But, unless they have had years of training from young and vigorous manhood on, he discourages late-comers against serious competition. Yet, "as a light-hearted pastime," says he, "it can be a joy and do a great deal of good." In this sense he urges his fellow dentists to take up the sport for relaxation. In virtually every large city in the United States there is a fencing club, as well as facilities in many colleges. Men who take up the pastime soon find themselves in a fellowship that covers the country and fosters a friendly individualism.

130 *West 57th Street*
New York City

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The DENTIST-

BOOKKEEPER

and TAX EXPERT

BY ARNOLD J. KOLLER, C.P.A.

As THE TIME approaches for many dentists to begin last-minute preparation of their federal income tax returns, it might be well to consider how a few hours spent wisely each month during the year can save you time and perhaps money next March 15. By an orderly arrangement of your daily transactions it is possible to avoid that frantic search through checkbooks and bank statements, bills to your patients, and from your dental supply houses; and to prepare your income tax return in a comparatively short time.

It is not only helpful, but it is required by the United States Treasury Department that you maintain permanent books of account. Nowhere are there regulations as to the type of records which should be kept. Thus, like the business man, you are allowed latitude in your choice as to the type and detail of the records you keep, so long as such records reflect clearly your income, expenses, and deductions.

In frequent discussions with dentists, I am asked such questions as, "What type of books shall I keep?" "Just what information is the Government interested in?" "How much should my books show?"

Before discussing some of these problems, let me dispell the objection I have heard frequently and which may be in your mind right now. You might be thinking, "But I'm no bookkeeper; I don't understand the mechanics of keep-

Efficient yet simple method of dental office bookkeeping can lighten next year's federal income tax burdens.

ing books." Of course, you are not a bookkeeper. The Government does not expect you to have the time and ability to keep a complete set of double-entry books. But this does not relieve you of the obligation to keep some permanent record of your income and expenses. Such a record may be a far cry from double-entry bookkeeping, but it must be kept with enough system to disclose the facts clearly.

First, let us discuss what records are best suited for the dentist's purpose.

Cash-Receipts Records

Since most of you will be keeping books on a cash basis rather than an accrual basis, the true measure of your income from fees will be the amounts received during the year, rather than the amounts earned. The most common method for recording cash receipts, the term used to denote checks as well as currency, is the use of a simple cash-receipts card. This card provides space for the date of the receipts, the patients' names, and the amounts received. A separate card is kept for each month.

All items of business income; that is, all amounts received by you in your practice, in cash or check; should be recorded on your cash-receipts card and deposited in the bank. Thus, your total receipts for any period, as indicated by your cash-receipts card, should balance with your bank deposit. Let us assume that you go to your bank every three days. During the three-day period your cash-receipts card shows receipts of one check for $40, one for $20, and $60 in cash. Your bank deposit for the period should be $120, the sum of the three items.

Non-Taxable Income

Suppose during this three-day period you received some non-taxable income, perhaps a $500 refund of income taxes. You would then have $620 to deposit in the bank. It is important that your records indicate the nature of this $500. But what records? Where? It does not appear on your cash-receipts card as it is not "business" income. The logical place for this, then, is in your checkbook or bankbook, when adding your deposit of $620. Indicate clearly that the $620 consisted of $120 from the receipt of fees and $500 from a tax refund. Unless you show all extraneous items in your deposits, it is easy to forget the nature of the items over a period of two or three years. Anyone who has had to explain to an agent of the Bureau of Internal Revenue why his deposits exceeded his income can appreciate this simple precaution.

Another problem related to income accounting is the proper determination of amounts owed you. "How much do patients owe me for services rendered?" Often I have found that the dentist is entirely unaware of the amounts owed by his patients and, in cases where monthly statements are sent to patients, the dentist has no method of checking the statements for accuracy. Let me briefly outline a system which I have found easy to understand and operate. It requires a minimum of record-keeping, and provides a satisfactory method of checking.

Record Debits

The first step is to determine how much is owed to you at the beginning of the period; let us say the first of the month. This information would come from either your treatment cards or separate patient cards. Thus, you will be able to separate those cards which show an amount due to you. The total of all such amounts will be the amount owed you at the beginning of the month.

Your next step is to keep a record of the value of the work performed by you during the month. This can be done easily in your appointment book. Each time you complete a case, if your charge is by the case; or each time you perform a treatment, if you charge for each treatment; it is a simple matter to record in your appointment book the charge for that visit. The total of such amounts for the month in your appointment book will be the sum total billed to patients for the entire month.

The amounts you charge each patient, as indicated in your appointment book, should be transferred to each patient's treatment card. As a precaution, to see that you are transferring to the right card, a glance at the treatment section of the card will indicate to you the service performed. Likewise, by transferring to each patient's treatment card the cash collected from each patient, you will be able to compute the amount owed to you by each patient at the end of the month in the following way:

Amount owed at beginning of month
Add: *treatment billed to patient during month*
Total
Deduct: *cash received from patient during month*
Result: amount owed by patient at end of month

Thus you will have the exact amount each patient owes you at the end of the month. The total of the individual cards will give you the total amount owed to you at the end of the month. Now, how can you prove your figures to be certain that you have not missed billing a patient for service performed or crediting a patient for cash received? Simply by doing in total as you did for each patient:

Total amount owed at beginning of month
Add: *total treatments (total for*

month in appointment book)

Total

Deduct: *total cash received (total for month from receipts card)*

Result: total amount owed at end of month.

The total of the amounts owed by each patient as shown by the treatment cards, must equal the total of your outstanding amount at the end of the month. You are now ready to send the statements to your patients.

Pay by Check

From a tax approach, this system of accounting for your receipts is ideal. The total of your cash-receipts cards for the year would equal the total of your bank deposits for the year (less explainable non-business receipts deposited) and the total amounts received from patients, as shown by your treatment cards. No agent of the Bureau of Internal Revenue could ask for more proof to substantiate your figure of gross income; provided there is no obviously conflicting evidence. If you are reporting an income of $5,000 to $6,000 and then manage to buy a home for $30,000 cash, and two new automobiles, it is only logical that questions would be asked as to the source of all that capital. Was it earned income? Were the earnings reported for tax purposes? Was it a gift? In such a case you must be ready with explanations and concrete, adequate proof of your explanations.

Since all of your receipts will be deposited in the bank, it is necessary to write a check for each disbursement of cash. This, then, is the basic rule of accounting for payments: Pay by check where possible and feasible. Your cancelled checks become your evidence of payment and, together with the bills and statements from your dental supply houses, make up your proof for the expenditure.

Petty Cash

A general exception to this rule is the method of payment for small items of office expenses. To pay such expenses, a petty cash fund of $5, $10, or even $25, according to your needs, is maintained in your office. However, remember that cash to renew this fund should be obtained by writing a check to petty cash rather than by extracting cash received from a patient. Do not violate the principle that all cash received should be deposited in the bank.

Checkbook stubs are a record of all your expenditures: supplies purchased, assistant's salary, rent, telephone, utilities, laundry and cleaning, meetings and conventions, dues and subscriptions, your personal withdrawals. Your expense break-down, of course, will be in accordance with your own needs. Note that it is advised to pay yourself a salary by check. This is additional proof, in case of a tax investigation, that all items of receipts and expenditures

are accounted for on your records.

To help you analyze cash disbursements in your checkbook, a cash-payments card or sheet is used. This is merely a columnar sheet on which each check can be classified as to the nature of the expenditure; thus enabling you to analyze your total expenditures for the month.

There is no "best" way to break down your expenditures as to type on your cash-payments sheet. However, I might suggest some columnar headings: laboratory costs, supplies, petty cash, meetings and conventions, dues and subscriptions, personal withdrawals, general. The general column is merely a catch-all for expenditures not classifiable in any other column. For example, with only the foregoing columns, the payment for rent would be entered in the general column.

By totalling the columns at the end of each month, you will be able to get a month-by-month analysis of your cash expenditures. A total of these figures at the end of the year will give you an analysis of your yearly expenditures. Knowing your receipts and expenses, it becomes an easy matter to prepare your income tax returns.

Any expense that is both ordinary and necessary is a deductible business expense. We do not have the space to discuss the interpretations by the Treasury Department of the meanings of these words, as applied to professional men. For example, certain expenditures for entertainment may be deductible; keep a record of them. Certain travel and automobile expenses may be deductible; keep a record of them. The cost of attending meetings and conventions, including the cost of meals, lodging and travel, may be deductible; keep a record of them. If your office is in your home, many of the expenses of the house may be deductible; keep a record of them.

Do not lose the benefit of a deduction for income tax purposes because of a lack of proof. The records are full of tax cases where the deduction was denied the taxpayer because of failure to prove the amount of the expenditure and its relation to his practice. Entertainment expense is a good example of such expenditures. During the year you must build up the proof for these deductions you claim in your income tax return. Have proof; be prepared; keep records.

The procedure just outlined has, in my experience, proved to be simple, yet complete and accurate. I have seen samples of "standardized" bookkeeping methods which are effective when properly followed. However, by using your own forms and methods, you can produce a simple bookkeeping system to meet the needs of your particular practice, according to the information you need or want, and the amount of time and effort you can put into it.

1775 *Walker Avenue*
Union, New Jersey

So You Know Something About DENTISTRY!

?

QUIZ LXVI

1. Calcifications in the pulp are present in varied amounts in (a) 20 per cent, (b) 59 per cent, (c) 90 per cent, of pulps. _____

2. True or false? Teeth in harmony with the skin in daylight will be harmonious under artificial light. _____

3. The greatest lateral growth in the dental arch occurs in (a) the third molar area, (b) the bicuspid area, (c) the cuspid area. _____

4. Silver nitrate desensitizers offer (a) greater margin of safety than, (b) the same margin of safety as, (c) less margin of safety than, the formaldehyde group. _____

5. Are deciduous supernumerary teeth common? _____

6. Liquid dentifrices containing no abrasives (a) assist, (b) do not assist, the toothbrush. _____

7. After fifteen minutes, a silicate cement restoration attains (a) 10 per cent, (b) 40 per cent, (c) 90 per cent, of its ultimate strength at fourteen months. _____

8. What is residual infection? _____

9. Follicular cysts are noted most frequently (a) during puberty, (b) in infancy, (c) between 50-65 years of age. _____

10. Is penicillin indicated in the treatment of Vincent's infection? _____

FOR CORRECT ANSWERS SEE PAGE 370

Dentists in the NEWS

Detroit (Michigan) News: Doctor Paul H. Jeserich, a dentistry instructor at the University of Michigan since 1933, recently was appointed dean of the School of Dentistry. Doctor Jeserich succeeds Doctor Russell W. Bunting, who is beginning a year's leave July 1 before retiring.

Doctor Jeserich has been director of the W. K. Kellogg Foundation Institute since 1936. He was responsible for the organization and development of an extensive postgraduate study program which was co-ordinated with the School of Dentistry's teaching schedule. A graduate of the Watervliet High School and the University of Michigan, Doctor Jeserich is a Past President of the Michigan State Dental Society and is Chairman of the National Advisory Committee for the Veterans Administration.

New York (New York) Times: That there is a definite association between the emotional status of an individual and the physical condition of his teeth and mouth was confirmed at the annual meeting of the Greater New York Dental Society by Doctor Samuel C. Miller, Professor of Periodontia at the New York University Dental College. Emotional factors play an important part from babyhood to old age: such disturbances in childhood may cause habits that can impair the teeth, and in old age cause neglect resulting in the loss of teeth. As an example, Doctor Miller cited chewing and biting habits which indicate emotional stress and a tendency to withdraw to the lesser responsibilities of childhood. Dentists, as well as physicians, should help such persons by explaining the reasons for their habits, for such habits are important causes of dental disturbances. Doctor Miller also pointed out that Vincent's infection is not contagious, as is commonly believed, but rather is often caused by emotional tension or physical exhaustion.

Thumb-sucking was a topic of much discussion by a pediatrician, psychiatrist, and a dentist at the accompanying meeting of the New York State Society of Dentistry for Children. All agreed that thumb-sucking beyond the age of 5 or 6 should be viewed with concern as a symptom of psychologic disturbance, and that the habit calls for psychiatric guidance. Doctor Louis B. Kelsten, Newark dentist, said that earlier thumb-sucking is due to physical and emotional needs and should not be restricted. Proper care and feeding can prevent abnormal prolongation of the habit.

Cleveland (Ohio) Plain Dealer: A room full of pipes is the result of a Cleveland dentist's collecting. Doctor Leo Stoor of 2859 Avondale Road, Cleveland Heights, has 300 pipes in all sorts of fancy woods, metal, stone, ivory, porcelain, and bisque. Doctor Stoor collected a variety of things—stamps, bayonets, guns, coins—until his wife tired of having her house cluttered and insisted that he "pick one and stick to it." He picked pipes, and now, in addition to his "pipe room," has several books about pipes, wears neckties with pipe designs, and is trying to form a Cleveland pipe collectors' club.

Among Doctor Stoor's favorites are

a carved wooden Bavarian pipe, the original one in his collection; and a French bisque pipe with a sculptured cavalier in pastel colors. Others include Arabic water pipes, Indian peace pipes, some eighty meerschaums, and a dainty, slender engraved pipe used by Japanese women. About a hundred of Doctor Stoor's collection were acquired while he served as Captain in the Army Dental Corps in Europe during World War II.

Southern California Alumni Review: Doctor George H. Flanders of Whittier, California, has a worthwhile hobby. It

is the civic project of planting trees along the streets and in the hills of Whittier where he is a practicing dentist.

Youngstown (Ohio) Vindicator: Five dentists who have been practicing for fifty years in the Youngstown district have been honored by the Corydon Palmer Dental Society of Youngstown. They are: Doctors T. J. Evans, F. E. Renkenberger, C. F. Blair, all of Youngstown; and Doctors K. C. Willis and J. W. Cartwright of East Liverpool. Guests at the honorary dinner were Doctor Daniel F. Lynch, American Dental Association Trustee and oral surgeon from Washington, D.C., and Mayor Charles P. Henderson of Youngstown. Doctor P. L. Connor presided at the dinner and Doctor H. G. Morris was program chairman.

Chicago (Illinois) Sun-Times: One-third, or 500, of Norway's dentists are women, and they are taking up the profession in increasing numbers, according to Doctor Jacob Ramm, head of Oslo's Municipal Dental Care for Children. "They find it pleasant as a life work, and they are able to give service. They are doing a very good job," said Doctor Ramm. Many of the women are general practitioners, although about two-thirds specialize in children's dentistry.

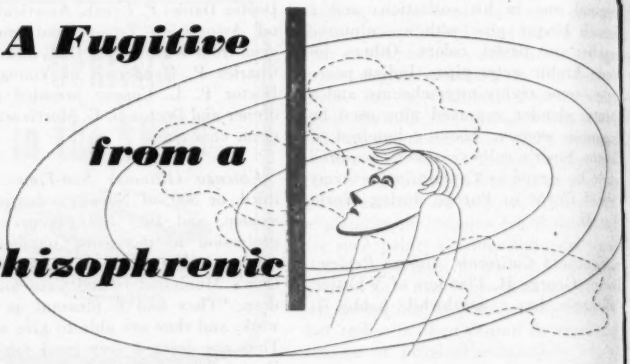
Doctor Ramm, formerly secretary-general of the Norwegian Dental Association, came to the United States to study the effects of fluorine and ammoniated dentifrices in preventing caries. He commented that Norway will extend its dental care plan next July to include treatment for adults as well as children in state-financed clinics at fixed rates. The plan is not like that of England, he asserted, because the patient pays the costs determined to be "reasonable."

About 925 dentists will be engaged in the clinic program, all under civil service, with adequate pay, vacations, and pension provisions. They also may engage in private practice, if they wish, after devoting the prescribed number of hours to their civil service positions.

Awards for items published in this month's DENTISTS IN THE NEWS have been sent to:

Fred F. Tomblin, 2523 Fifty-Fifth Street, Huntington Park, California.
P. L. Connor, D.D.S., 401 Stambaugh Building, Youngstown, Ohio.
Roy Denial, 12033 Woodmont, Detroit 27, Michigan.
Ruth E. Renkel, P.O. Box 695, Elyria, Ohio.
M. B. Newman, D.D.S., 1410 Morris Avenue, Bronx 56, New York.

A Fugitive from a Schizophrenic



BY JOSEPH MURRAY, D.D.S.

IT CERTAINLY can do no harm to be on the alert for patients suffering from emotional strain or even more serious mental ailments (psychoses). Witness the incident concerning one prospect who walked into my office wanting to have a tooth extracted: "Doctor, this tooth hurts like blazes!" he said. "I want it pulled!"

I never did extract the tooth, because before I was finished taking his case history I realized that he needed a psychiatrist. Unfortunately for me, however, discharging the patient did not spell finis to the episode.

While sleeping peacefully and soundly, I was awakened by the incessant ringing of my doorbell, at 5 a.m. sharp, some two weeks after the already forgotten experience. Looking through the peep-hole in the door of my combined office-residence, I was amazed to discover my mentally disturbed patient.

Yelling at the top of his voice, "Open up, Doc!" while pounding furiously at the locked door; he created a commotion that was frightening. I slipped an envelope containing two aspirin tablets through a tiny space underneath the door.

"Swallow these pills," I said. "And come back later in the day, when I am not so sleepy." However, he was not to be denied. Fortunately, his telephone number was recorded on the history chart. In response to my call, his wife answered, saying that he had taken to wandering the streets in the early hours of the morning, and that she was powerless to stop him. Of course, the family had failed to consult a psychiatrist, as I had

Some knowledge of psychiatry is protection for dentists.

recommended, she told me apologetically. "We thought his 'nervousness' would disappear after a little rest at home," she said.

After advising her that I would call the police to take him home, I discovered that he had disappeared as suddenly as he had come.

A short time later, his wife visited me personally to tell me that her husband's ailment was diagnosed as schizophrenia, and that he was at a sanatorium undergoing a "rest cure."

Irrational Patient

The events leading up to my recognition of another psychotic patient may be of interest to my colleagues:

Here was a mature, married man of thirty, presenting himself for treatment, accompanied by his father. My suspicions were aroused immediately. Why should an adult come with his father in the first place? Of course, if a gas extraction were indicated, and there was no one to escort him home, we could justify the father's presence. Once I began to question him, however, my doubts seemed well-founded, because the parent attempted to answer all my questions.

Moreover, the patient began to talk irrationally: "The right side hurts, Doctor. No, it must be the left side. No, it's both sides. Better pull all my teeth, Doctor!"

Then he grasped both my hands, in a vice-like grip. For a moment I thought I would need help to escape from his maniacal hold. In a trembling, yet soothing voice, I said, "Now, take it easy, Mr. H.; let go of my hands and I will stop your toothache." As he relaxed his grip, I made a pretense of dabbing some medication on one of his teeth.

"Has your son been a little 'nervous' lately?" I asked the father, after I had somewhat regained my composure.

"No, no," he stammered. And his furtive manner and expression belied his statement.

"Better take your son to a neurologist right away," I said. "Waiting may be dangerous. You can come back with him after you have seen the doctor," I continued. To myself, I thought, "The sooner they leave, the better I'll like it." I heaved a great sigh of relief when father and son finally did make their exit.

Since I am no psychiatrist, it is not my purpose nor intent to diagnose mental ailments and prescribe treatment. However, a few pertinent observations are in order. Certainly, no harm can result from discussing them.

Symptoms of Schizophrenia

First, the patient was no longer living in the realm of reality. When I first saw him, he was suffering from what psychiatrists call manic-

depressive psychosis, a disease of the mind—a functionally emotional state characterized by periods of elation, flightiness, increased motor activity (manic) and low spirits with mental and motor activity (depressive type). In other words, the ailing person has periods of elation and depression.

At the time that he had presented himself for treatment, the patient was definitely in the manic, or "fighting-mad" stage. He certainly was not responsible for his actions, which undoubtedly could have brought harm to an innocent bystander or to himself.

It might also be of interest to know how a neurotic differs from a psychotic.

The former never escapes from reality. He may be compliant, aggressive, or detached. He may have certain fears or phobias. He may have compulsions and obsessions. He may feel hopeless and apathetic. But he will know what is going on around him. He will never lose sight of reality.

Not so with a psychotic. Here, the patient is truly mentally ill. His escape from reality is complete. He definitely requires the services of a psychiatrist. Usually, hospitalization, proper medical care, and nursing are indicated.

The schizophrenic, especially, often has a persecution complex. Many times he has delusions that he is being followed or that his food has been poisoned. That he requires expert medical care is irrefutable; that he has no place in a private dental practice is understandable.

That dentists learn how to differentiate between normal, neurotic, and psychotic patients is almost mandatory. For self-protection, better dentist-patient relations, and peace of mind, the study of psychiatry offers fertile soil. The public libraries, medical and dental societies have all the information you need. It is yours for the asking.

1358 *46th Street*
Brooklyn, New York

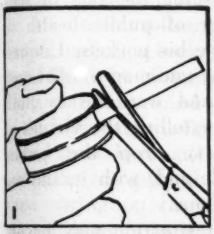
CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News* (see page 362) we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

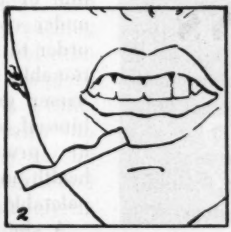
TECHNIQUE of the Month

Conducted by W. EARLE CRAIG, D.D.S.
Drawings by Dorothy Sterling

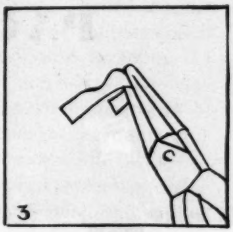
Matrix for Inserting a Gingival Plastic Filling



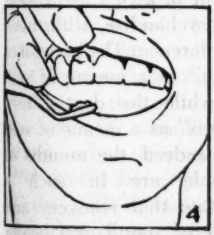
Using 9/32″ steel matrix ribbon, cut off a piece about 1-¼″ long.



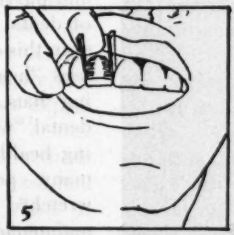
Trim band to fit interproximal contours.



Contour band to fit carious area.



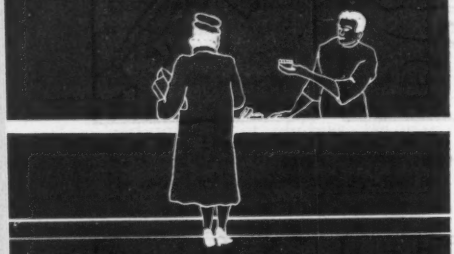
Prepare cavity and insert plastic filling material.



Seat steel matrix over filling material. Pull the excess matrix material tight at the lingual. Use "stimudents" to hold band in place in the interproximal spaces.

After 15 minutes, remove matrix. Polish filling with wet abrasive and felt knife-edge disks.

Dentistry's GROWING PAINS



BY DAVID TABAK, D.D.S.

Is good dentist-patient relationship threatened by necessity of merchandising in dentistry?

WERE A HAT manufacturer to urge me to wear a hat under penalty of baldness, sickness, and possible death, he might be correct; but, I would be inclined to smile at his solicitude. At best, I refuse to take him seriously and brush him off good-naturedly; at worst, I accuse him of pushing the sale of hats under cover of public health in order to line his pockets. Unquestionably, the salesman would be on firmer ground were he to limit himself to extolling the virtues of his product; drop the public health angle and, with it, the unpalatable sham.

A similar situation may be observed in the dentist-patient relationship where the dentist is cast in the dual role of health-teacher and purveyor of a rich assortment of dental merchandise, with, however, this difference: The hat-maker uses "health" as a means of selling hats, while the dentist uses dental "wares" as a means of selling health. Indeed, the mouths of many people are in such a wretched state that recovery and maintenance of sound oral health can be brought about by no other means.

Just the same, the question that plagues the sensitive practitioner is: How can the dentist act the

disinterested teacher and guide in matters of dental health and, at the same time, feel he is involved in the "sale" of inlays, jackets, bridges, and dentures? Can he still emerge with the assurance that his dignity, pride, and ethics remain untarnished? When a dentist is called in to rebuild a defective masticatory apparatus, he has to employ the aid of props and crutches and artificial parts of every conceivable shape and form; and he may find himself virtually behind a counter at Macy's. Can he stand there, solemnly preaching health against a backdrop of cabinets filled with glistening samples? Does that not remind you, a little, of the legendary medicine man who would first harangue his gaping audience on general health and then spring on them his mystic cure-all bottle of snake oil?

What if the patient asks, "Doctor, am I getting the best treatment?" Would the answer be, "No, you are getting the next best." Or, would it be: "Yes, you are getting the best," and let the patient discover later that there is a better way; that is, a more expensive way. Or, should the dentist merely outline the various methods of treatment for a given case and let the patient choose? This is what most of us probably do, but is this procedure conducive to building faith in the dentist? What would a patient think of a surgeon if he offered an appendectomy in three different ways at three different fees?

So far as general medicine is concerned its overall purpose is to maintain and prolong life. But so far as dentistry is concerned, it is not enough to say that its overall purpose is to maintain and prolong the life of the human dental arch. While it is unnecessary for the general surgeon to consider the esthetics of a hemorrhoidal operation; the dentist's field is out front where appearance is of the essence; where vanity often takes precedence over health.

Are we drifting toward a generation of dental shopkeepers? When dentistry was in its swaddling clothes there was no such problem to dog our footsteps. Dentists of dubious background and rawest of training would go about "pulling" teeth, replacing them with crude substitutes and laying no claim to professional status. Today, the very complexity of the problem is, in a sense, a measure of the profession's prodigious growth. We no longer "pull" teeth; our restorations are marvels of scientific, artistic, and therapeutic accomplishments. But, we grew too fast; we suffer from an excess of alternatives. Almost every simple restoration can be, and is, done in twelve different ways; using as many different materials and charging as many different fees. As a result, we are forced to show printed illustrations, or draw outlines of a "plan"—not unlike an architect's—or show real "samples" of various types of restorations, explaining their virtues and

prices. Often, we must even arrange with banks and finance companies for loans to the patient; planning schedules of time payments, legal contracts, and notes. Wherein does all this differ from the business of a shopkeeper? Meanwhile, we try to maintain an aura of pure professionalism.

Our Dilemma

The strain of this tight-rope walking is intense. We find ourselves prescribing for the dental health of our patients, not in terms of grains, grams, drams, and minims, but in the number of pontics and number of units in metal castings; and all this from a member of a health profession! And yet, how else? These are our tools, no matter how unsavory from the point of view of medicine. We seem caught in the meshes of a dilemma.

However, I think there is a solution. If you will pardon my temerity, I should like to see the dental profession divided into two major component parts: (1) Dental Medicine and Surgery, and (2) Plastic Surgery. The first needs no explanation. The second would be placed in the same category and on the same level with general plastic surgery. Such an act would at once formalize and professionalize the present jungle of restorative dentistry and give a tremendous lift to our pride which too often is forced to take a nose dive. Since all dental restorations are virtually face-lifting operations, they should be so classified. That done, our dental surgeon would immediately merit a place as a "doctor" in the eyes of the public as well as in his own. Incidentally, a fee of several hundred dollars would shrink into insignificance when compared, say, to a fee charged for the removal of crow's feet from a woman's wrinkled face.

Attention, Council on Dental Education!

270 *South Third Street*
Brooklyn 3, *New York*

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ LXVI

(See page 361 for questions)

1. (c) 90 per cent. (Grossman, L. I.: Handbook of Dental Practice, Philadelphia, J. B. Lippincott Company, 1948, page 42)
2. True. (Clark, E. B.: Selection of Tooth Color for the Edentulous Patient, J.A.D.A. **35**:791 [December] 1947)
3. (c) the cuspid area. (McBride, W. C.: Juvenile Dentistry, ed, 4, Philadelphia, Lea & Febiger, 1945, page 189)
4. (a) greater margin of safety than. (Manley, E. B.: Should Dentin be Desensitized?, Brit. D. J. **85**:49 [August 6] 1948)
5. No. (McBride, W. C.: Juvenile Dentistry, ed. 4, Philadelphia, Lea & Febiger, 1945, page 108)

6. (b) do not assist. (Accepted Dental Remedies, ed. 14, Chicago, American Dental Association, 1948, page 117)
7. (b) 40 per cent. (Pearson, F. T.: Silicate Restorations, J. Canad. D.A. **14**:423 [August] 1948)
8. An infection that remains either in the soft tissue or in the alveolar bone after the removal of teeth or other surgical operations of any nature. (Mead, S. V.: Oral Surgery, ed. 3, St. Louis, C. V. Mosby Company, 1946, page 501)
9. (a) during puberty. (Ehrich, W. E.: Pathology, Philadelphia, Lea & Febiger, 1941, page 224)
10. Yes. (Accepted Dental Remedies, ed. 14, Chicago, American Dental Association, 1948, page 60)

NATION-WIDE SURVEY OF DENTISTS' INCOMES MADE BY U.S.

DENTISTS ENGAGED in private practice in 1948 had an average net income of $6,912, which represents dollar earnings 60 per cent above 1929, and 80 per cent above the prewar high attained in 1941. These figures were revealed by the Office of Business Economics, U.S. Department of Commerce in announcing the results of its survey in 1949 of the incomes of 78,000 dentists.[1]

An average net income of $7,047 was reported by 71,760 dentists engaged in private practice, while salaried dentists, who represent 8 per cent of the practitioners, received on an average $5,358 in 1948.

Of every 10 dentists, slightly more than 2 earned less than $3,000, and a similar proportion reported net incomes in excess of $10,000.

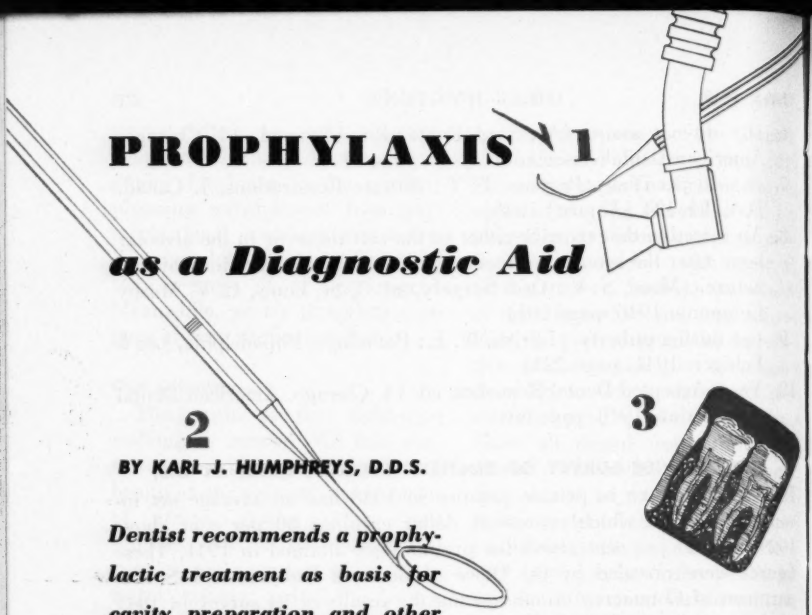
Compared with the economic demand for dental services, the study indicated that the geographic distribution of dentists is overconcentrated. As has been the case for at least the last decade, dentists in the Far Western region of the country had a higher average net income in 1948 than those in any other section of the country.

Dentists practicing in cities having between 25,000 and 250,000 population (middle-size cities) reported higher incomes than those in either small communities or in metropolitan centers. New York City (with almost one-ninth of the Nation's dentists in 1948) had a lower average dental income than the national average for all dentists. Philadelphia and Chicago also had dental incomes below that for the country as a whole. Of the large cities studied, only San Francisco and Los Angeles had average incomes substantially above the national average.

Income increased sharply as age increased, until a peak average net income of $9,117 was reached for dentists 40-44 years of age. After that the income declined steadily. The proportion of older dentists was shown to have increased markedly in the last decade.

[1]U.S. Department of Commerce, Office of Business Economics Survey of Current Business (January) 1950.

PROPHYLAXIS as a Diagnostic Aid



BY KARL J. HUMPHREYS, D.D.S.

Dentist recommends a prophylactic treatment as basis for cavity preparation and other dental services.

THIS IS A plea for the application of simple dental prophylaxis by the dentist, as an aid to diagnosis. Of course, other things are to be gained also. Let us go into this subject in more detail.

The patient presents himself in your office for a check-up or examination. Just what do you do? You examine the mouth with a mirror and explorer; it takes only a few seconds—not minutes. You listen to the patient's complaints and look at the areas called to your attention: the big broken-down tooth you can see; the places where teeth are missing are observed (and they cause a gleam in your eye). You suggest roentgenograms and your conversation turns to that. This idea is easy to get across to the patient; the roentgenograms are your basis for diagnosis; you know that, and so does the patient.

The roentgenograms are taken, and again you examine the mouth with the explorer, compressed air, and the mirror. By this time, generally speaking, there is gingival bleeding if the patient has any gingivitis— and most of them do.

You have the films and you see what is wrong. The patient returns; you start to prepare cavities, make extractions or impressions, as the case may be. But you are operating in an unclean field and cannot see as well as you should; you spend time rinsing away the blood and

muck. The patient remarks about bleeding and everybody is working under a handicap. You have prepared one cavity, or more. The bleeding tissue is an impediment, so you put in a temporary stopping and let the patient go; saying to yourself, "That will push the gingiva away and I can make some progress next time." So it goes; you struggle with the case, though on this basis the end result is not good. Finally, you do everything you can see that is necessary and then, as the final touch, you give the patient a prophylaxis.

If you had started your case with examination, roentgenograms, and simple prophylaxis, you would know a great deal more about the mouth and you would have had a clean field in which to operate. The gum tissue would not be spongy and difficult to handle. One or several prophylactic treatments by the dentist himself should be your basis for this start; of course, immediate and urgent things such as relief of pain take first place. But, generally speaking, you will be well-rewarded by such a procedure.

Recommended Procedure

If you employ a hygienist, let her give the final prophylaxis. She does not attempt the dentistry; you do that. She might tell you what she sees, and even write it down for you, but you will gain more knowledge about the case at hand by doing your own prophylaxis at the beginning than by any other method of which I know.

Now, as to procedures and technique: The instruments for simple prophylaxis are hook scalers, the old-fashioned college scalers, a few spoons, some pumice or optical abrasive, a little sodium perborate, right angle brush, port polisher and right angle rubber cup, cutter floss, and a not too new contra angle headpiece.

Scale the teeth, but not too deeply. If this is painful, use a little topical anesthetic such as a 2 per cent benzocaine. Actually, this has little effect, but the patient appreciates the effort. When teeth are scaled, take a small amount of abrasive and add about equal parts of sodium perborate to it, and a little water. Then with the brush and rubber cup proceed to brush the teeth; using the floss charged with this mixture between the teeth. Have the patient rinse his mouth.

At the next appointment, if your first prophylaxis is incomplete, repeat the procedure. You have the roentgenograms now and you have seen the mouth and teeth; you should know a little more than if you had merely looked at the area. You know about the gingivitis; you have an idea about the caries; and you are acquainted with the patient. The gingivae do not bleed, so you can form a somewhat definite opinion as to how to start repairing the damage in the dentures.

234 *East Colorado Street*
Pasadena, California

EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

HUMANICS IN DENTISTRY

IN AN ADDRESS before the Royal Society of Medicine the philosopher, Bertrand Russell, said that two attitudes are common to mankind: rage and listlessness. People meet life situations by getting angry and excited about them or being utterly indifferent to them. Each extreme is wrong. When people get too wrought up about something, out of all proportion to the real threat involved in the situation, they are skirting close to the danger zone of the manic psychotic. When nothing can stir them from their lethargy and they show no interest in people or events, they are at the other extreme of the psychotic scale—hebephrenia.

If we are suffering such a warpage of the personality as to be declared psychotic, we should be put out of harm's way. We can still be full of rages and hostilities without being so far gone that we are ready for institutional care. Think of the people who are raging over the conditions in politics, business, society generally. At the other extreme are the listless—those so lacking in interest that their house could burn down around them without producing any reaction.

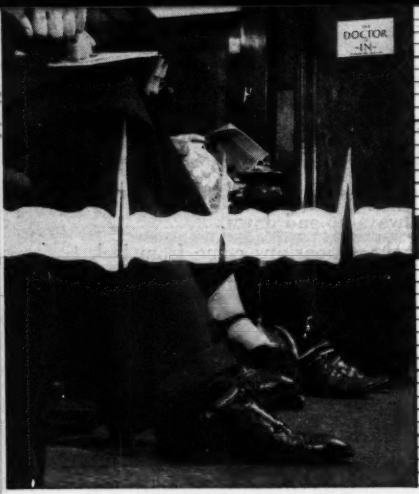
We see the extremes of rage and indifference among our patients and our colleagues; in fact, among all mankind. Some patients are querulous, complaining, angry at us and the world. They jump from one dentist to another; they shift their loyalties and enthusiasms abruptly. They make "bad" patients because they are undependable and blistered with suspicions and hostilities. At the other pole are the patients so indifferent that they have no regard for appointments, obligations, or hygiene. They are mobile masses of protoplasm that are lacking in reaction and response. They too are "bad" patients. Between the extremes are all the

thousands of people who react "normally"; that is, they are neither explosive-violent nor sluggish-apathetic. But even these normal people, as you and I, have variables and pulsations in response. Behavior is never a straight line on a graph. It is always up and down.

Most of our troubles in inter-personal relationships come from lack of understanding of the human equation. The equation is the personality which is a living continuum of past experiences, present and future hopes and aspirations. Added to experience and hope are the dark mysteries of inherited and constitutional traits. Man is not a simple system that can be manipulated by a few easy rules or tricks. A lot of salesmanship and some higher level psychology is built on the fallacy that learning a line of chatter, working to a formula, makes a success in inter-personal relations. These pat devices may work on some people and up to a point, but whoever depends on rules from a sales manual or on a few stereotyped tricks is pointed toward trouble—and he should be.

In almost every dental group I find well-trained and skillfull young dentists who lament that they have received no instruction in the humanics of dental practice. They were trained to recognize the common forms of disease and indoctrinated in the usual methods of treatment. They spent long hours in memorizing atomic weights, the origin and insertion of muscles; but no one told them much about the human personalities that play the roles of dental patients. From the day a youth enters dental school until the day he graduates he should be impressed with the fact that dentistry is concerned with people; often people under the shadow of pain and tension. Along with the techniques of manipulating things, he must know something of the techniques of managing people—and himself.

Edward J. Ryan



The Dentist and His Heart*

BY R. KENNETH THOMSON, B.Sc., M.D.

DESPITE THE wonderful increase in average life during the past century, the life expectancy of those who pass 60 is no greater now than it was years ago. The longest lived centenarians appear to be those with a good family history of longevity, who have lived active physical lives in rural areas.

Some relationships other than age are climate, race heredity, and social and financial status. It is generally conceded that a mild, dry climate is most suitable from a cardiac point of view. In New Zealand the average age is about two years greater than in the United States. The intense cold of certain periods of our northern winters is not favorable for cardiac disease. Good but not rich foods are of value, and moderate exercise and healthful and uncrowded living conditions tend toward health from a general and cardiac point of view.

Your major question is undoubtedly: "Where does the dentist stand in these relationships? Is his occupation one which is attended by hazards which make the occurrence of heart disease likely?" You have gained the impression that your colleagues have frequently developed coronary sclerosis at an early age and that many have died young. You wonder then if it is the posture of the dentist, the fatiguing nature of his occupation, or his habits which are responsible.

*Condensed from the Journal of the Canadian Dental Association.

Improve your health by lessening the tension in your dental office.

Available information does not indicate that alcohol is directly deleterious to the heart. It will, of course, produce secondary reactions, with increase of heart rate and palpitations, which are likely to be upsetting to anyone who is at all apprehensive. These symptoms are referable to the heart but not indications of heart disease *per se*. Smoking is another habit which has been labelled as a cause of heart disease by many and denied by just as many. It also may lead to rapid heart action or to extra systoles, but the consensus appears to be that it does not cause heart disease. Recent evidence, however, has pointed a finger at tobacco in that the incidence of death in people with cardiovascular disease appears to be higher among those who are heavy smokers.

Medical men have also had the feeling that members of their profession were dying more frequently and at a younger age from heart disease, but a recent study does not indicate that they vary greatly from the average population. No complete analysis of dental surgeons has been made but there is nothing to indicate that they would be different from the medical profession; and there is nothing to indicate that the dental surgeon's activities are particularly destructive to the heart musculature or vessels.

We do know that marked curvature of the spine with alteration of the rib cage can produce a mechanical embarrassment to the heart. We also know that the dentists' occupation carries with it postural strain, and frequently pains caused by that strain; but there is no evidence that this occupational disability ever leads to a sufficient spine or rib cage deformity to produce mechanical heart embarrassment.

Having tried to disabuse your minds of the idea that the practice of dentistry makes you liable to heart disease, I should like to mention the existence of symptoms which are often referable to the heart. Since they are referable to the heart, they are in a sense important and certainly command our attention and require explanation.

Tension

Dentistry is meticulous and painstaking, calling for concentration and skill. There are frequently the added difficulties of poor light, and muscle fatigue from cramped position and upright posture. There is a tension on the part of the patient with a fear of pain; there is an attempt on the part of the operator to avoid that pain and its sequelae of restlessness or displeasure on the part of the patient. There is, moreover, the constant attention to detail which is neces-

sary to produce good results; and of course the constant desire for good results which will be appreciated by colleagues as well as the patient. These days there is the added strain of trying to include that extra patient in an already crowded appointment schedule, and with that the fear of giving something less than the best attention to the patient.

All of these factors are productive of strain or tension—which manifests itself both physically and mentally. In dental surgery there are always uncertainties and irritations which lead to fear and anxiety. This is present in all human beings, though in some the emotional response to stresses and strains is greater than in others.

These emotions have a physical as well as a mental side. Acting through the autonomic nervous system we find responses in the heart, the breathing, the gastrointestinal tract, and the secretory system. These responses may be rapid heart action, rapid breathing, undue sweating, or tremor of the limbs, and are in many respects similar to the fear reaction which may occur in all animals.

The importance to us is that we are often aware only of the abnormal sensations of palpitation, weakness, or tightness in the chest; and without consideration of the possible cause we are likely to think, "It's my heart!" This of course produces another worry and still further physical manifestations of worry. We are all aware of the acute physical response to some major trial or mishap, but we are often unaware of the fact that we are working under constant minor tension or strains, and so we incorrectly interpret the physical symptoms associated with them.

Your heart will not suffer, but your peace of mind is disturbed, and I recommend to you any change in office hours, routine, or conduct which would lessen the strains of life, or which would make you less unpleasantly responsive to them. Too full an appointment book may not be the best way to lead a full life.

Edmonton
Alberta, Canada

THE COVER

THIS MONTH'S cover carries an interesting aerial photograph of Atlanta, Georgia, scene of The Thomas P. Hinman Mid-Winter Clinic, which will be held from March 19 to 22, 1950, under the auspices of the Fifth District Dental Society. Since the first clinic was held thirty-seven years ago, under the direction of the distinguished dental surgeon, Thomas P. Hinman, these scientific meetings have continued to grow in prestige. Doctor Sidney L. Davis, General Chairman for 1950, is confident that the lectures and postgraduate training offered in this year's clinic will again command the respect and interest of dentists throughout the country.

ASK Oral Hygiene

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Loose Dentures

Q.—In reading your answer to A.-J. P., Wisconsin, in ASK ORAL HYGIENE[1] relative to treatment of a patient who has Parkinson's disease, and particularly to the cause of his loose dentures, requiring them to be made over every year, you give one of the probable causes as loss of weight.

Well, I finished dental school in 1909 and, if I am not mistaken, we were taught that there was no adipose tissue in the mouth, and certainly not in the gingivae; and regardless of a person's body weight, it would not change the gingivae. I am sure I have made a good many hundred dentures over the years, and from my experience, I would say that change in a person's weight has no effect on the fit of his dentures. Have I been wrong all these years?—T. G. O'H., Minnesota.

A.—We are always grateful to readers of ORAL HYGIENE who comment on certain questions and answers, so I thank you for writing about my answer to A.J.P.

We have had dentures loosen when patients lost much weight, so we have assumed that with the loss of general weight and diminution of bulk there was some diminution of bulk of the oral tissues. Considering the necessity of a close contact between a denture and the supporting mucosa, an extremely minute change in bulk of the ridge would result in loosening a denture.

Now as to there being no adipose tissue in the mouth, Orban[2] has this to say about the oral mucous membrane: "The submucosa consists of connective tissue of varying thickness and density. It attaches the mucous membrane to the underlying structures. Whether this attachment is loose or firm depends upon the character of the submucosa. Glands, blood vessels, nerves, and also adipose tissue are present in this layer."—GEORGE R. WARNER.

Decalcified Areas

Q.—In ASK ORAL HYGIENE[2] a question on "Gingival Conditions" was answered. Do you first use benzine and then nacconal powder followed by zinc chloride and then potassium ferrocyanide, or, at what point is nacconal used? Where can nacconal be obtained? —R. W. P., Minnesota.

(*Continued on page 382*)

[1]ASK ORAL HYGIENE, Parkinson's Disease, ORAL HYGIENE, **39**:750 (May) 1949.

[2]Orban, Balint: Oral Histology and Embryology, St. Louis, The C. V. Mosby Company, 1944, p. 263.

Portraits and Profiles

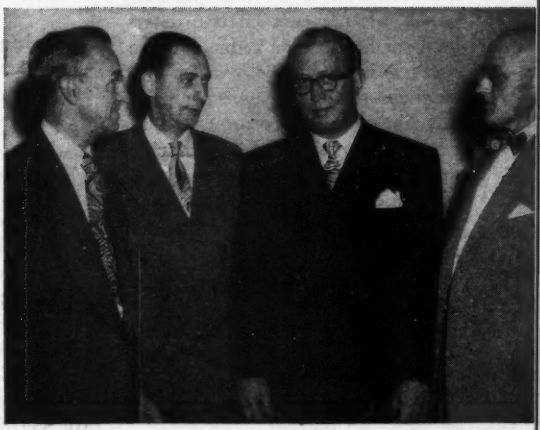
Of American Dentists

By Howard A. Hartman, D.D.S.

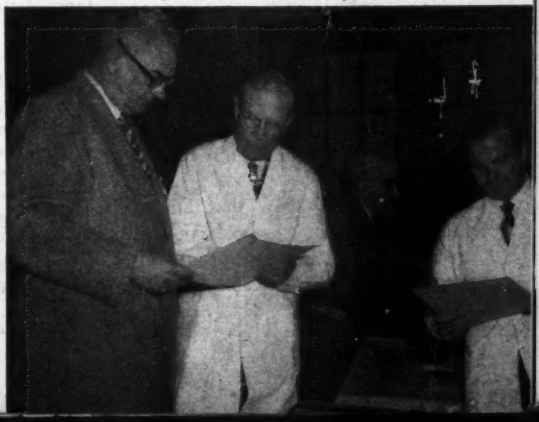
American Academy of Restorative Dentistry at San Francisco ADA meeting: (Left to right) Lester Bryant, President, Chicago; Kenneth A. Bignell, Secretary, Chicago; and E. Bruce Clark, Retiring President, Pittsburgh.

Frank M. Casto, Past President of ADA and Dean Emeritus of College of Dentistry of Western Reserve University, greets William C. Stillson of the faculty of Reserve from Cleveland.

(Left to right) Leon R. Kramer, Topeka, Kansas: Paul W. Zillman, Buffalo, New York; Fred A. Richmond, Kansas City, Kansas; Clinton L. Stalker, Topeka, Kansas; Arthur J. Buff, Topeka; William M. Sexton, Bristol, Virginia; and Samuel S. Cohen of Cleveland; at the San Francisco meeting.



(Left to right) W. C. Smolenske, Denver; Arch S. Lawson, Pittsburgh; Joseph D. Shriber, Los Angeles; and Harold C. Van Natta of Lakewood, Ohio.



American Academy of Periodontology: Allison G. James of Beverly Hills, California, studies the clinic presentation of Paul J. Boyens, San Francisco, and Carl F. Mills of Concord, California. Both clinicians are members of the teaching staff of the College of Physicians and Surgeons.

ASK ORAL HYGIENE

(*Continued from page* 379)

A.—Here follow the details of the Gottlieb impregnation. A one per cent aqueous solution of nacconal is used and your druggist should be able to get it for you.

Gottlieb's solution: First, the teeth are isolated by cotton rolls and washed carefully with benzine (do not use chloroform or ether); then the tooth is covered with nacconal, one per cent (it is a detergent surface tension reducer). The tooth is immediately covered with zinc chloride, 40 per cent; then the zinc chloride is permitted to remain one minute. Zinc chloride must be kept from the gingivae. The zinc chloride is precipitated with potassium ferrocyanide, 20 per cent.—GEORGE R. WARNER.

Dislocation of Joint

Q.—For the past six or eight years I have noticed in some of my women patients a popping in the mandibular sockets when yawning, opening the mouth, or chewing food such as meat. I have not noticed this in a single man patient. Will you please advise me as to the cause of this and what treatment is indicated?—W. C. J., South Carolina.

A.—I have delayed answering your letter until I could consult some of my confreres, and particularly an anatomist, in regard to your question.

Our records show that almost all of our patients who have had trouble with the temporomandibular joints were women; and my friends report the same experience. No one has given a particularly satisfactory reason for this. The anatomist said that the musculature of joint region in men is generally heavier than in the case of women; and that this may account for the difference in the matter of this particular disorder.—GEORGE R. WARNER.

Sterilizing Agent

Q.—What is the phenol coefficient of thymol? Is it advisable to use it as a liquid (by heating) for sterilizing in cavity preparation instead of phenol followed by alcohol? What about thymol in a 10 per cent solution of alcohol? —W. M. K., New York.

A.—Thymol is considered a much better sterilizing agent[8] for carious dentine than phenol. It can be liquefied with chloroform and thus, in its application to the dentine, one would have the advantage of the obtunding effect of the chloroform. As alcohol has little sterilizing action, there would be no advantage in using it in any stage of the cavity preparation.—GEORGE R. WARNER.

Calcium Therapy

Q.—Would you kindly give me the latest information on calcium therapy for women during pregnancy?

My information is that the taking of calcium concentrates does little or no good, as the calcium is eliminated in the same form and almost the same

[8]Day, H. W.: Thymol in Cavity Sterilization, J.A.D.A. **31**:605-615 (May) 1944.

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quantity as ingested. Many of the physicians in this region prescribe calcium to their women patients during pregnancy or recommend that they consult their dentists on this matter. I should like to be in a position to give those who consult me the latest information. —J. J. H., New York.

A.—The obstetricians in Denver more or less routinely prescribe calcium in tablet form for their pregnancy cases. They tell me that they have to use calcium in this form in many cases because their patients do not tolerate milk, because milk causes constipation, or because patients gain weight.

You are right about there being quite a loss of ingested calcium. Wright[4] has this to say about absorption of calcium: "Absorption is always incomplete, about 75 per cent of the ingested calcium being excreted in the feces. The amount absorbed is increased when the calcium of the bowel is present in a more soluble form. Thus, when the acidity of the small intestine is increased, acid calcium phosphate is formed and more absorption occurs; conversely, increased bowel alkalinity gives rise to insoluble $Ca_3 (PO_4)_2$ and Ca Co_3, and less absorption takes place."—GEORGE R. WARNER.

Tongue Pressure

Q.—I have a 60-year-old patient with a full upper and lower lingual bar who complains that his food balls up in his mouth in a dry mass; and he cannot swallow his food. The dentures seem to fit well and there is neither soreness nor irritated areas. Both are acrylic dentures. He has lost twenty pounds trying to eat with the dentures in his mouth. Since he removed the upper denture and ate using only the lower partial, he has been able to swallow his food. Can you offer advice on this point?

We are also enclosing models of a young woman's mouth, age 32, whose intermaxillary space seems to be enlarging. Ten years ago the upper and lower anterior teeth contacted each other. As you can see from the models, there is quite a bit of space between them now. Can you advise me as to the cause and treatment in this case?—J. V. S., New Jersey.

A.—Does this denture patient have a high or narrow arch? You might try altering the shape of the arch with hard baseplate wax to see if you cannot arrive at a form of the palate that the tongue will clear of foods during swallowing.

Your 32-year-old patient is no doubt forcing the separation of her anterior teeth with tongue pressure. She probably places her tongue between her teeth at night when she sleeps. Or she may place it there every time she swallows. An operation on the throat; for example, a tonsillectomy, sometimes results in a patient thrusting the tongue forward between the anterior teeth when swallowing.

If you or the patient can break this tongue habit the teeth will return gradually to their normal position. Fitting orthodontic bands to a bicuspid on each side, carrying a wire with sharp spurs on it across the palate just back of the teeth, sometimes helps to remind a patient to keep the tongue where it belongs.—V. CLYDE SMEDLEY.

[4]Wright, Samson: Applied Physiology, Oxford University Press, 1937.

ny dentist doesn't hurt!"

THIS little girl has never known fear of dental pain. Why not? Her dentist makes sure she isn't hurt, by the use, whenever indicated, of Novocain-Pontocaine-Cobefrin. ▲ Elimination of dental pain by *any* means is well worth while . . . but what simpler, more economical way than by use of this fine local anesthetic solution? The deep, dense, lasting anesthesia which "N.P.C." creates effectively blocks out dental pain; as a consequence, patients have no dread of going to the dentist. ▲ Such thoughtfulness on your part means better tooth care for your patients, more cooperative patients for you. Add the two together, and the result is better dentistry for all.

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Husband: "Well, honey, the car broke down and I had to fix it."

Local Wife: "Since when do you grease your car with red grease?"

★

Henpeck (who has just overheard his wife scolding the maid): "You and I are both in the same unfortunate position, Mary."

Maid: "Not exactly! I'm giving her a week's notice tomorrow."

★

The two stones most commonly associated with marriage are the diamond and the grindstone.

★

Mr.: "Aren't you ready to go yet?"

Mrs.: "Tell me, does my gown look as if it were slipping off my shoulders?"

Mr.: "No, let's go."

Mrs.: "Well, you'll have to wait. It's supposed to look that way."

★

Brother: "I had a very dull evening with that blonde you introduced me to."

Sister: "Impossible! She knows all the answers."

Brother: "I'll say. And she also no's all the questions."

★

The president called his office manager in and thrust a letter under his nose.

President: "Look at that! I thought I told you to engage a new stenographer on the basis of her grammar?"

Office Manager (looking scared): "Grammar? I thought you said glamour."

★

First Girl: "I'm sure there's a man following us."

Second Girl: "Gosh! What shall we do?"

First Girl: "Let's match for him."

★

"Would you kiss me even if I told you not to?"

"I sure would."

"Oh goody! Now I can mind mamma."

★

Boss: "I can't imagine what I'd do without you."

Secretary: "Well, I've been here a year, and you still haven't imagined what you could do with me, honey."

★

Air Pilot: "Have you heard the remark, 'See Naples and die?'"

Passenger: "Yes."

Air Pilot: "Well, we are over Naples and the engine is not functioning."

★

Father: "Well, Willie, what did you learn at school today?"

Willie (proudly): "I learned to say 'Yes, sir' and 'No, ma'am.'"

Father: "You did?"

Willie: "Yeah."

★

A pretty girl sat in the corner of her compartment next to her young man, her litle niece on her knee. The train dashed suddenly into a tunnel and finally the other passengers heard the little girl exclaim: "Kiss me, too, Aunt Violet."

"Mavis," said Aunt Violet very quickly, "you should say 'kiss me twice!' Kiss me, too, is not good grammar."